Washington State WIC Nutrition Program

REQUEST FOR MEDICALLY NECESSARY WIC APPROVED FORMULAS

Date: _____

Client Name: _____ Date of Birth: _____

Caregiver Name (if client is infant or child): _____

1. Medical Diagnosis warranting the issuance of a Medically Necessary WIC Approved Formula:

- ❑ Food Allergy
- ❑ Metabolic Disorder
- ❑ Gastrointestinal Disorder
- ❑ Malabsorption Syndrome
- ❑ Inborn Error of Amino Acid Metabolism
- ❑ Other Serious Medical Condition (describe) _____

2a. Brand Name of the WIC Approved Therapeutic Formula or Child Nutritional prescribed**:**

- ❑ Enfamil A.R. LIPIL
- ❑ Enfamil EnfaCare LIPIL with Iron
- ❑ Enfamil Nutramigen LIPIL
- ❑ Similac NeoSure Advance with Iron
- ❑ Similac Alimentum Advance
- ❑ PediaSure *(Child Nutritional: Only for children one year of age and older)*

2b. Brand Name of the WIC Approved Standard Formula prescribed:

- ❑ Enfamil w/Iron
- ❑ Enfamil LIPIL
- ❑ Enfamil Gentlease LIPIL
- ❑ Enfamil Prosobee LIPIL
- ❑ Enfamil Lactofree LIPIL

Women and Children: Select one of the above WIC Approved Standard Formulas, or select the brand of formula listed in box 2a.

Infants: The use of this form is not required for any of the WIC Approved Standard Formulas listed in box 2b.

3. Length of Time the prescribed Medically Necessary WIC Approved Formula is required:

- ❑ 1 Month
- ❑ 2 Months
- ❑ 3 Months
- ❑ 4 Months
- ❑ 5 Months
- ❑ 6 Months

4. Name and Signature of Prescriptive Authority

Name:_____ **Phone**:_____
(print or stamp)

Signature:_____ **Date**:_____
(required)

- WIC is a supplemental food program. It does not provide all of the formula a woman, infant or child may need each month.
- A subsequent form must be completed if the formula continues to be medically necessary after this time period.
- The medical diagnosis must correspond with the necessity of the prescribed formula. A symptom description such as "fussy baby" is not a medical diagnosis.

Return completed form to WIC client or to the local WIC clinic.

WIC Clinic Name:_____ **Phone #:**_____ **Fax #:**_____

Questions? Call your local WIC clinic or the Washington State WIC office at 1-800-841-1410

Rev 08/06

BABIES WERE BORN TO BE BREASTFED. WIC SUPPORTS BREASTFEEDING.

WASHINGTON STATE WIC NUTRITION PROGRAM
INSTRUCTIONS TO COMPLETE THE:

REQUEST FOR MEDICALLY NECESSARY WIC APPROVED FORMULAS FORM

A. Client information: Enter the following data:

- **Date** the form is completed
- **Client Name**
- Client's **Date of Birth**
- **Caregiver Name** (if client is an infant or child)

1. **Medical Diagnosis warranting the issuance of the Medically Necessary WIC Approved Formula:** Check the appropriate medical diagnosis requiring a Medically Necessary WIC Approved Formula. The medical diagnosis must correspond with the necessity of the prescribed Medically Necessary WIC Approved Formula. If "Other serious medical condition" is marked, describe the condition. The Medically Necessary WIC Approved Formula will not be provided if a Medical Diagnosis is not checked.

   Note: A symptom description such as "fussy baby" is not a medical diagnosis.

2a. **Brand Name of the WIC Approved Therapeutic Formula or Child Nutritional prescribed:** Check one of the boxes indicating the WIC Approved Therapeutic Formula or Child Nutritional prescribed. The WIC Approved Therapeutic Formula or Child Nutritional will not be provided if a Brand Name is not checked.

2b. **Brand Name of the WIC Approved Standard Formula prescribed:** Check one of the boxes indicating the WIC Approved Standard Formula **only** if prescribed for a woman or child. The WIC approved Standard Formula will not be provided if a Brand Name is not checked.

3. **Length of time the prescribed Medically Necessary WIC Approved Formula is required:** Check one of the boxes indicating a 1, 2, 3, 4, 5, or 6 month time period. A subsequent form must be completed if the Medially Necessary WIC Approved Formula continues to be medically required after the number of months indicated. The Medically Necessary WIC Approved Formula will not be provided if a Length of Time is not checked.

4. **Name and Signature of Prescriptive Authority:**

   a. **Name: Print or Stamp:** Print or stamp the name of the licensed health care professional with Prescriptive Authority.

   b. **Signature and Date:** All forms require the original signature of a licensed health care professional with prescriptive authority. The Medically Necessary WIC Approved Formula will not be provided without the Signature of the Prescriptive Authority.

   c. **Phone:** Print or stamp the phone number where the licensed health care professional with prescriptive authority can be contacted.

B. Return completed form to the WIC client or to the local WIC clinic. The information on the completed form is confidential. Assure confidentiality when mailing or faxing this form. Do not mail or fax this form to the Washington State WIC office.

C. WIC Clinic Name, Phone # and Fax #: WIC clinic staff have the option to enter this information onto the form. This information communicates to the prescriptive authority where to return this form.

For a copy of this form, visit: http://www.doh.wa.gov/cfh/WIC/clinic.htm

Washington State Department of Health

DOH Pub 961-001 (Rev 02/06)
For persons with disabilities this publication is available on request in other formats.
To submit a request, please call 1-800-525-0127.

BABIES WERE BORN TO BE BREASTFED. WIC SUPPORTS BREASTFEEDING.